Deployment Quarterly

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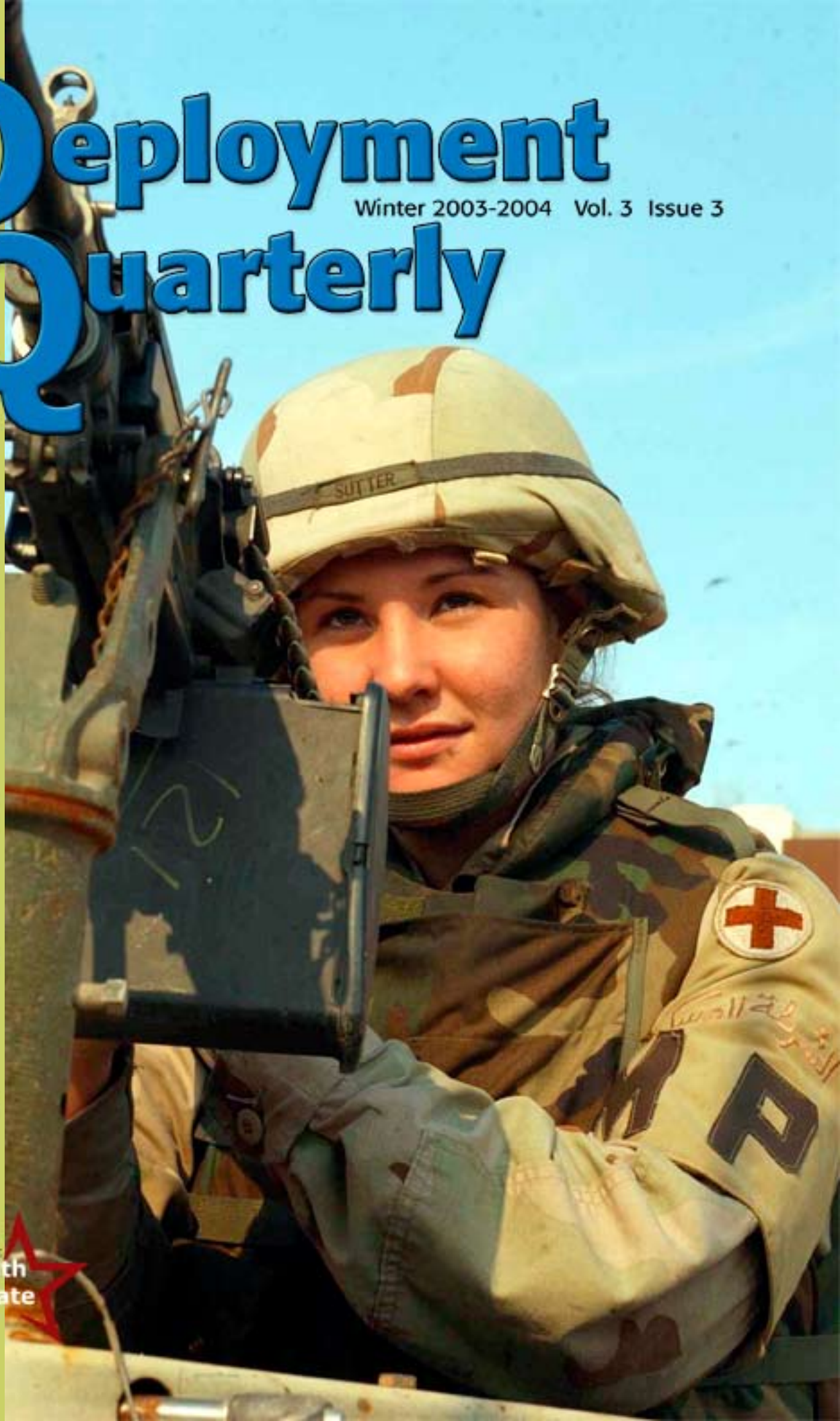

U.S. DEPARTMENT OF DEFENSE
Deployment Health Support Directorate

DIRECTOR'S message

Dear Readers:

The Department of Defense's force health protection strategy has revolutionized the way we preserve and protect the health of servicemembers. It is being transformed by advancing technology and the lessons learned since its inception.

Force health protection is a life-cycle system that provides a full range of quality health services to servicemembers and their families throughout their career. Through it we provide a fit and healthy force, protected from all health threats across the full spectrum of military operations, and supported by mobile, technologically advanced clinical teams that effectively treat any injuries andillnesses that occur.

The military health care system's infrastructure services support the three pillars of force health protecton. That includes training, logistics, information management technology, and research and development. In the future, these infrastructure support services will have to become more joint and more responsive as military needs continue to evolve. This has to happen in a time of major doctrinal shifts in casualty care and management. The new doctrine calls for the delivery of essential care in theater and evacuation to definitive care outside the theater of operations as soon as possible. It demands that the Defense Department establish an advanced joint evacuation system that can support movement of casualties from point of injury or illness to point of care.

Currently, the military health care system plans and trains under a threat-based doctrine, rather than capability based requirements. Using threat-based planning, we develop forces and systems based on a specific threat and scenario. This fosters a "bottom-up, stove-piped" approach that is neither "coordinated with other components nor linked to the National Military Strategy. Because they are not fully joint or interoperable, new programs often fail.

Force Health Protection is not just about doctors caring for servicemembers. To succeed, the concepts of force health protection must also be understood and implemented by commanders, service members, planners and even the public. Force health protection offers the tools, techniques and guidelines needed, but success requires the involvement of much more than just the medical force. Medical personnel play a key role in all elements of force health protection, and they will continue to deliver world-class medical care, but the pillars of force health protection go beyond their capabilities alone. Force health protection requires a true partnership between line elements and medical elements. As force health protection matures, cultural change within the military medical system will become more and more necessary. Comprehensive force health protection will require continued adjustments in force structure, concepts of employment, information systems, and other domains.

Overall, the implication for force health protection is that the old ways of doing business are no longer sufficient and need to be replaced by a new joint paradigm. Force health protection is our most diverse warfighting system, and it must become fully integrated across all operational concepts and within all functional areas.

We have the technology to meet most of our force health protection requirements, and technical solutions for the remaining requirements are on the horizon. But changing the cultural values and ideals of medicalprofessionals, the forces they support, and the public they defend requires a concerted effort and clear description of the benefits of, and need for, force health protection.

Sincerely,

Ellen P. Embrey
Director, Deployment Health
Support Directorate

Deployment Quarterly

The Deployment Health Support Directorate

Volume 3 **Issue 3**

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LETTERS: Letters to the editor must be signed and include the writer's full name, city and state (or city and country) and mailing address. Letters should be brief and are subject to editing.

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winter 2004

U.S. Army photo by Spc. Clinton Tarzia

Soldiers of Battle Company, 5th Battalion - 20 Infantry, 3rd Brigade, 2nd Infantry Division (Stryker Brigade Combat Team) form a perimeter during a patrol in Samarra, Iraq, on Dec. 15, 2003. The 3rd Brigade, 2nd Infantry Division (Stryker Brigade Combat Team) is under the operational control of

Features

On the Cover

Spc. Janet Sutter, a gunner with the 233rd Military Police Company, 519th MP Battalion, 18th MP Brigade, pulls security with her M249 squard automatic weapon in Baghdad.

U.S. Army photo by Staff Sgt. Marvin L. Daniels

In Every Issue

Sgt. Maj. of the Army: Stresses Safety As A Top Priority Among Soldiers

by spc. lorie jewell
army news service

In his first few weeks as the Army's top enlisted soldier, Sgt. Maj. of the Army Ken Preston, said he's getting a crash course on the 'big picture' Army while zeroing in on key issues he'll focus on.

"Right now, I need to understand a little bit of everything across the board," Preston said during his first "Sergeant's Time" interview as sergeant major of the Army with Soldiers Radio and Television. "The Army staff is doing a wonderful job in getting me smart. Once they finish, I'll really start focusing on a couple things I can make a difference on over the course of the next three or four years."

Safety is one of those issues. With a mandate from the secretary of defense to reduce the accident rate by 50 percent, Preston plans to spearhead plenty of dialogue about the subject. So far this quarter, 79 soldiers have died in accidents — 20 more than the first quarter of fiscal year 2003, Preston said. From fiscal years 2001 to 2003, the number of accidental deaths in the Army jumped from 168 to 255, according to the U.S. Army Safety Center at Fort Rucker, Ala.

"It's about not becoming complacent," Preston said. "It's ensuring soldiers out there follow procedures established in policies, regulations, operating manuals."

Sergeants have a responsibility for enforcing the standards, for making sure soldiers aren't taking short cuts or taking things for granted, he added.

Preston acknowledged that the current fast-paced operations tempo plays a role in the accident rate, but stressed he believes awareness can make a difference.

"We have 325,000 soldiers in more than 120 countries across world, and eight divisions in transition. The operations tempo is much higher, but nevertheless when a soldier dies because of accident, particularly when it could be prevented, it's a tragedy," Preston said. "I really think that the more we focus on it and the more we talk about it, even with the current pace of operations, we can reduce the rate."

The Army's most pressing priority at the moment is the global war on terrorism and upcoming troop movements into and out of theaters, Preston said. But leaders are also focused on concurrent goals, such as transitioning from a current to future force that remains relevant and ready, he added.

"As the Army changes and evolves, so must other things," Preston said. "One of the things I want to look at is the future of the non-commissioned officer education system. It needs to evolve to take into consideration the modern battlefield we're currently on."

The Army's current design and organization was for the cold war-era fight, for a time when the good guys were at one end of the battlefield, the bad guys at the other, and they met in the middle for a "clash of the Titans" type battle, Preston explained.

"It is truly now a 360-degree battlefield," he said.

Training centers like the National Training Center in California and the Joint Readiness Training Center in Louisiana are evolving to incorporate the lessons soldiers are learning in Afghanistan and Iraq, Preston added. Emphasizing the warrior's ethos is another way of mentally preparing soldiers for the new battlefield.

"The warrior's ethos is what quantifies what soldiers are about today," Preston said. "If you look at what's going on in Iraq, all soldiers there are warriors. The mentality that every soldier is a rifleman first is so, so important."

Balancing the force is another way of better preparing for the new battlefield. Preston said the Army's 100 artillery battalions were designed, again, for the cold war era. That number will be pared down, while other units in heavy demand — military police, for instance — will be increased. The current 33 brigade combat teams will be refigured into 48 brigade units of action, he said.

Such changes will not only make the Army more modular and better able to quickly deploy, but will offer soldiers more predictability in when they'll deploy, Preston said.

Soldiers are encouraged to e-mail Preston at *smaweb@hqda.army.mil* with their questions and concerns. To learn more about the Sergeant Major of the Army, go to his Web site at *http://www.army.mil/leaders/SMA/*. ■

Editor's Note: Sergeant Major of the Army Kenneth O. Preston was sworn in as the 13th Sergeant Major of the Army on January 15, 2004. He serves as the Army Chief of Staff's personal adviser on all enlisted-related matters, particularly in areas affecting soldier training and quality of life.

No War Trophies Allowed From Iraq, Afghanistan

ASHINGTON — Do not even think about bringing back to the United States war trophies from your service in Iraq and Afghanistan.

With about 140,000 American servicemembers due to rotate out of Iraq and Afghanistan, U.S. Central Command officials are very clear that servicemembers cannot bring home weapons, ammunition and other prohibited items.

A few soldiers of the 3rd Infantry Division understand how serious the command is. Some soldiers tried to smuggle weapons back from Baghdad, and they have gone through courts martial. Others received Article 15 administrative punishments.

"There is a whole spectrum of punishments, depending on the severity of the offense," said Maj. Robert Resnick, an Army lawyer at Fort Stewart, Ga.

Army Gen. John Abizaid, the commander of U.S. Central Command, has put out the policy. Basically, under no circumstances can individuals take as a souvenir an object that was formerly in the possession of the enemy. The taking of war trophies goes against the coalition mission in Iraq and Afghanistan, officials said.

"We didn't go into Iraq or Afghanistan to conquer them, but to liberate them," said Marine Capt. Bruce Frame, a CENTCOM spokesman. "Taking articles from those countries sends the wrong message."

Servicemembers with questions should work through the chain of command, CENTCOM officials said, adding that servicemembers will be given ample briefings on what is allowed and what is not. In the case of Iraq, unit commanders will brief servicemembers on the policy before leaving for Kuwait.

In Kuwait, military police will explain the policy and will permit an amnesty period before searching gear and vehicles. In the United States, U.S. Customs Service officials will examine individual gear.

In Afghanistan, unit commanders will explain the policy, and military police there also will explain it and offer an amnesty period before the servicemembers board the planes. Again, custom officials will examine gear and baggage upon return to the United States.

The same prohibitions pertain to American civilians serving in the Central Command area of operations.

Other federal laws pertain to other items. For example, servicemembers cannot bring back plants, animals or other organic materials. Some Marines returning from Afghanistan in April 2002, for example, tried to bring back the skulls of sheep attached to their guidons. The Customs agents met the Marines as they landed on the beach at Camp Lejeune, N.C., and confiscated the items.

No one can bring back antiquities into the United States, and of course, no one can bring drugs or drug paraphernalia into the United States.

The overall prohibition does not pertain to souvenirs that can be legally imported into the United States, officials said. ■

Casting Call

U.S. Navy photo by Photographer's Mate 3rd Class Jason R. Williams

Aboard the USS Kitty Hawk (CV 63) — Hospital Corpsman 3rd Class Jontae Moreau, from Saratoga Springs, N.Y., applies cast material to the arm of Damage Controlman Fireman Juan Campos, from Orange County, Calif. This is one of the many procedures Kitty Hawk's medical department may perform in a normal day at sea.

New Tax Relief Act Aids Servicemembers, Families

WASHINGTON — Legislation signed by President Bush on Veterans Day in 2003 increases the death gratuity payment to $12,000 and provides that the full payment is tax-free.

That portion of the Military Family Tax Relief Act of 2003 is retroactive to Sept. 10, 2001, to provide for servicemembers who died in the terrorist attacks the following day and in the ongoing global war on terror, said Army Lt. Col. Janet Fenton, director, Armed Forces Tax Council.

"If you are killed on active duty, regardless of whether you're in theater, or in a training accident or die from disease, your family receives $12,000 death gratuity that is not taxed," she added. "And that's a big change. In addition any future increases to the death gratuity will remain tax free."

The death gratuity has been $6,000 since 1991, with half of it being taxed, said the director. "It just didn't seem to be fair for the military family who was left grieving for their service member to get hit with a tax bill," she added.

Capital gain exclusion for home sales is one of the most common areas people were looking for tax relief in, said Fenton. "This act will allow members to suspend the period of time which they have to sell their home and take the tax exclusion so they won't have to pay that capital gains," said Fenton. "It's retroactive to 1997 so military members who have sold their homes since 1997 have one year from Nov. 11, 2003, to request a refund for any tax they did pay."

Since 1997, when the law was previously changed, if service members who owned a home got reassigned more than 50 miles from that home or were ordered to move on post, they were no longer able to roll over the gain from that sale to the next home they purchased.

Also since 1997, individuals could exclude up to $250,000, or $500,000 for married couples, of gain from the sale of a home if they resided in the home for two of the five years preceding the sale. Under this act, military and Foreign Service personnel can suspend — for up to 10 years — the time transferred away from home on official extended duty for purposes of applying the five-year portion of the two-out-of-five-year rule.

The 2003 act also includes above-the-line deduction for overnight travel expenses of National Guardsmen and Reservists who have to travel more than 100 miles to attend drills or meetings.

"The act allows for an above-the-line, which means you don't have to itemize your taxes to take advantage of this deduction," said Fenton. She added that servicemembers will "be able to deduct unreimbursed travel expenses such as lodging, 50 percent of meals and any transportation costs. "This part of the act is retroactive to Jan. 1, 2003."

When the tax code changed in 1986, it said any military benefit existing in September 1986 would remain tax-free, said Fenton. However, it was always unclear whether military child care was included in that, she added. "This act merely makes it clear that those provisions of child care were intended to be tax-free to military members."

The tax act also provides for extra tax-filing time for troops serving in contingency operations. The internal revenue code allows servicemembers who are serving in combat zones or hazardous duty areas to have an extension of time — usually 180 days from the time the person leaves the combat zone — to file taxes.

"A lot of military operations don't rise to the level of being declared by the president as 'combat,'" said Fenton. "But there are several contingency operations where servicemembers are outside the continental United States."

The act also includes modifying eligibility criteria of tax-exempt veterans organizations; tax-free treatment of homeowners' assistance program payments; suspension of tax-exempt status for designated terrorist organizations; and extension of victims' tax relief to astronauts who die on space missions. ■

Arabic-Speaking Marine Chosen As Linguist Of The Year

U.S. Marine Corps photo by Lance Cpl. Ruben Maestre

CAMP LEJEUNE, N.C. – Marine Sgt. Chad E. Lindsey, an Arabic linguist and vehicle commander assigned to 2nd Radio Battalion, II Marine Expeditionary Force, poses next to his light armored vehicle specially outfitted for signals intelligence and electronic warfare. Lindsey, a native of Woolrich, Maine, received recognition on Nov. 7, 2003, as the Marine Linguist of the Year and runner-up Linguist of the Year for the Department of Defense. Next to Lindsey, is the name of his vehicle, "Jolly Roger," written in Arabic.

ASK doc

Q Why are so many soldiers in Iraq catching that skin condition called leishmaniasis?

A We discussed leishmaniasis in the Fall 2003 issue, where there was a description of the disease and its impact. Since then, the total number of cases of skin leishmaniasis among American troops in Iraq and Afghanistan has risen to more than 500. This infection shows itself as one or more open skin sores or ulcers — "Baghdad boil" — that can enlarge and form disfiguring scars. Although the skin form of this infection will eventually heal itself, treatment is recommended for cases where there are many sores or the sores are large. The usual treatment is an investigational drug called Pentostam, although other treatments are being studied.

The parasite that causes leishmaniasis is spread to people by the bite of infected sand flies. During the sand fly biting season — March to November — in Iraq, there are plenty of sand flies around. Even before the coalition forces entered Iraq, it was well known that leishmaniasis was common there. U.S. military studies have confirmed the presence of sand flies in great numbers and have shown that as many as 2 percent of them in some areas are carrying the parasite. The recent increase in cases is due to bites during the last biting season. It can take weeks to months before the sores appear at the site of the bites.


Dr. Francis L. O'Donnell

Because there is no effective vaccine or protective medicine against this disease, the best way to avoid getting this infection is to keep from getting bitten by the sand flies. Each soldier in the field has to do this himself. There are three ways to repel the sand flies, and service-members in Iraq and Afghanistan should do them all.

First, when the weather permits, troops should cover as much of their skin as possible with their uniform. Clothing is a strong mechanical barrier that keeps the bugs away from the skin. Second, the uniform or other outer clothing should be pretreated with the repellant called permethrin. A single, good uniform treatment will last for months, even with laundering. The purpose is to keep the sand flies from even landing on the uniform, from where they could move to exposed skin.

Third, troops should apply DEET repellant to their exposed skin. Military supplies of DEET lotion are stronger and last longer on the skin.

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vaccines DRUGS & HERBS

Q *I have been taking a couple of prescription medications for quite some time, and now I am about to deploy overseas to a hot, arid, inhospitable country. I have been given the OK by our medical officer, but there are a lot of little nagging questions I have about storage, quantity to take, getting refills, etc. Can you provide some general information on this topic?*

Thank you for the question. Let me say you are doing the single most important thing when it comes to taking your medication. Which is, not being afraid to ask questions! It's the only way you can make informed decisions, stay within defined military rules and regulations, and use your medicines in a safe and wise manner. Additionally, you were correct in seeing your unit's medical officer for clearance and deployablity and have been given the OK. You are on the right track. Here is some additional information that may be helpful:


Cmdr. Gene DeLara, MSC, USN

Store your medications wisely.

Being on a deployment can present some challenges for safe storage of your medications, particularly if you are in a job that requires you to be in a field environment. However, it's not impossible and common sense goes a long way. Keep your medications in the original container. Those amber prescription bottles are actually very good at protecting the drug from dust, moisture, rough treatment, and other things one experiences when out in the environment. But, remember they weren't designed for the field. You must do your part to keep your medications away from heat and moisture, which may reduce its potency or even totally render them ineffective.

Take at least a three-month supply.

Before leaving on deployments visit your military pharmacy. Usually

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DoD Issues Medical Management Policy For Depleted Uranium-Exposed OIF Veterans

by joan kennedy

In keeping with its strong commitment to ensuring the health of servicemembers and civilian personnel, the assistant secretary of defense for health affairs recently issued a policy for the medical management of individuals exposed to depleted uranium during Operation Iraqi Freedom. The guidance clarifies who, why, when, and how the military services should test for possible depleted uranium exposure during and after deployment and combat operations.

"For some 70 Gulf War veterans who were in the highest depleted uranium exposure group and subsequently enrolled in the [Department of] Veterans Affairs' depleted uranium medical follow-up program, the medical community has yet to identify any untoward health consequences a decade after their exposure on the battlefield," said Craig Postlewaite, D.V.M., M.P.H., who leads the environmental health team in the Department of Defense's Deployment Health Support Directorate.

The purpose of the new policy is to identify and test those who may have been exposed to significant levels of depleted uranium while deployed.

According to Postlewaite, the policy directs compliance with an approved medical protocol following sound clinical practices; standardizes the way depleted uranium tests are performed; and helps DoD meet its obligations for ensuring the health of our deployed personnel.

> *"The medical community has yet to identify any untoward health consequences a decade after their exposure on the battlefield.*

When depleted uranium munitions penetrate armored vehicles or when depleted uranium munitions burn, aerosols made up of very fine particulates are generated. Individuals are exposed to depleted uranium when fragments embed in the body or when depleted uranium particulates are ingested or inhaled.

The DoD policy for medical management is based on level of exposure. Level I includes individuals who were in, on, or near combat vehicles at the time they were struck by depleted uranium munitions, or who entered immediately after the strike to attempt rescue.

Level II includes individuals who routinely entered vehicles damaged by depleted uranium rounds as part of their military occupation or who fought fires involving depleted uranium munitions.

Level III includes individuals who have driven through smoke from depleted uranium munitions fires, who have entered or climbed on or in battle-damaged vehicles that may have been contaminated with depleted uranium, or who had other infrequent and short-time exposures, which are considered incidental in nature.

"Experience from the 1991 Gulf War indicates that individuals with incidental exposures are unlikely to have experienced any significant exposure to depleted uranium," said Postlewaite.

Dr. William Winkenwerder, the assistant secretary of defense for health affairs, directed the military service surgeons general to identify all Operation Iraqi Freedom servicemembers with possible Level I and II exposures to DU so that their exposures may be clinically assessed. Those with primary responsibility for identifying possibly exposed individuals are commanders and medical officers in the field.

Another key method to identify those servicemembers who may have been exposed involves the completion of a DoD Form 2796, "Post Deployment Health Assessment," at the time of redeployment. Any returning deployed individual who indicates a possible exposure to depleted uranium on this form will be referred to a health care provider to determine the exposure level.

To document any Level I or II exposures that may have occurred, the policy requires testing of the urine for the presence of depleted uranium. For Level III exposures, depleted uranium testing is not required, but medical care providers may order the testing if needed for medical management or to address concerns of the individual.

The DoD policy also specifies that after wounds are treated and the patient is fully stabilized, depleted uranium fragments should be removed unless the medical risk to the patient is too great.

Two potential hazards associated with exposure to large amounts of depleted uranium are heavy metal toxic-

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U.S. Army photo by Pvt. Daniel D. Meacham

A soldier from the 4th Infantry Division in an M1A1 Abrams tank guards the north gate at the Al Mosul Airport in Mosul, Iraq.

Deployable Civilians Provide Valuable Expertise

by capt. amie brockway
air combat command public affairs

hen their units are called to deploy, they line up for their smallpox and anthrax shots, they pack camouflage uniforms and dog tags, they get weapons training, and brush up on their self-aid and buddy-care skills. But these warriors are not airmen — at least not in the traditional sense.

They are Air Force Engineering and Technical Services civilians who work shoulder-to-shoulder with the active-duty force, providing continuity and years of expertise to aircraft maintenance and communication units Air Force-wide.

Though they are noncombatants, the civilians deploy worldwide with their units supporting the Air and Space Expeditionary Force. Being willing to deploy is part of their job description and a condition of their employment.

Of the 540 AFETS civilians throughout the Air Force, 325 are assigned to Air Combat Command. More than 90 percent have served in the military before transitioning to a similar field as a civilian. They bring with them an average of 15 years of technical expertise, said Dr. Frank Malone, chief of the Combat Air Forces Engineering and Technical Services division.

"We don't hire people right out of high school or college. We want people who bring technical expertise to the table," Malone said. "When you put three or four [of our civilians] together, you probably have about 50 or 60 years worth of experience. They are the go-to guys when you have the most critical technical problems."

The AFETS program began in 1966, but limited guidance and logistical constraints made deploying its civilians difficult until 1990, he said.

Deploying civilians became easier when they began to be viewed as an integral part of the total force concept, said Bob Harmon, acting chief of the division's communications team.

"Becoming a part of the deployment footprint allowed the military to not only [use these civilians] more easily, but we also began to train for the deployment phase, as well for the technical requirements," Harmon said. "Now we have better guidance in place. [The civilians] are part of any Phase-I inspection. So now when we deploy our civilians, we have line numbers associated with them, just like the active duty side."

Many prior-service civilians see few differences between their former lives in the military and their current lives. They said they still enjoy the training and camaraderie of the military but have exchanged titles like "airman" and "sergeant" for "Mr." and "Ms."

"When I deployed to the Middle East after Desert Storm, I was part of an air control squadron. It was almost like being back in the military," said Rich Miller, an ACC command system integrator who spent 12 years in the Air Force. "I found a lot of acceptance in my unit from my active-duty counterparts because they felt I was a very important part of the team effort."

As a civilian technician, Miller said much of the acceptance was fostered before the unit deployed, while he was training military technicians for worldwide contingencies.

"You stand in line with them at the immunization line, put your gas mask on during exercises and deploy to the field when the unit is practicing local communication exercises. When you are tasked to deploy, you process the readiness line, get on an airplane and land in a foreign country ready to accomplish the mission," he said.

But civilians in the field today do more than that, Miller said.

"They not only train and deploy with their home units, but they are constantly [on temporary duty], assisting other … units with training and technical support," he said.

In the past decade, the number of civilian deployments has increased significantly. They have filled 150 deployment requirements since Sept. 11, 2001, Malone said.

"As the blue-suit environment geared up, we got busier. We mirror the [operations tempo] of the active duty force," he said. "The more the Air Force draws down, the more AFETS [civilians] are called upon. We used to provide the technical assistance by phone. Now they want us on site at the deployed location."

The program has gained greater acceptance by commanders in the

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Ask The Doc

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than commercial, over-the-counter products. Military DEET is a free supply item and doesn't have to be applied as often as commercial products, most of which contain the same active ingredient — DEET — but, just less of it.

Sand flies do most of their biting after dark, so the precautions described above should be emphasized every evening. As a supplement, if troops can sleep under a fine bed net that has been sprayed with permethrin, they can increase their level of protection.

Getting back to the original question, studies have shown that soldiers need constant reminders and reinforcement to keep up their guard against biting insects. It's easy to forget to use the repellant. It takes diligence and discipline to apply repellant several times a day, especially during the hot weather of the biting season, when it may not be pleasant to put lotion on the skin. Some troops prefer to use commercial products, but they don't last as long.

Furthermore, some troops have relied on bogus remedies that not only don't work but also are potentially dangerous. Examples are wearing pet flea and tick collars and eating match heads. The chemicals in these are absorbed into the blood stream and are potentially toxic. If they actually worked and if they were safe, they would already be commercially available.

The uniform and repellants are safe and effective barriers to sand flies and greatly reduce the risk of leishmaniasis. ■

Vaccines, Drugs

—Continued from Page 5

a three-month supply of medications is authorized for someone going on deployment. There may be some exceptions for some type of drugs, but talk with the pharmacy staff. They will be more than happy to assist you. The new Tricare Mail-Order Pharmacy, which began in March 2003, may also be useful if you are in a location conducive to receiving mail packages. This can include temporary, APO and FPO addresses. For information on Tricare Mail-Order Pharmacy visit its Web site at *http://www.tricare.osd.mil/pharmacy/tmop.cfm*.

Be familiar with your medication.

Know both the generic and trade name. It's interesting how many times people will say, "I forgot to bring my blue blood pressure medications," but when asked the name of the drug, they haven't a clue. Medications often are beneficial, but they must be taken seriously. In addition to knowing the drugs' name, you should also know what the drug does, the strength, how much to take, how long to take it, any side effects and what to do if they occur, what you should do if you miss a dose or two, and any precautions. Some medications make you extremely sensitive to sunlight. If you are going to a desert environment, you know you will be exposed to a lot of sunlight.

Do not give your prescription medication to other people.

This can be very dangerous. The medication is for your specific medical condition and may not be the correct treatment for someone else. For active duty personnel, any prescription medication you are taking must be recorded in your medical record.

Again, the most important advice I can give is use common sense. If you have any doubts or further questions when on your deployment, ask your medical folks. I appreciate the question and your dedication. Keep charging ahead. ■

Cmdr. Gene de Lara, Medical Service Corps, U.S. Navy, serves as the medical planner in the Deployment Health Support Directorate. He has a doctorate of pharmacy and a masters of business administration. De Lara is both a pharmacist and medical planner, holding the 1805 Plans, Operations and Medical Intelligence specialty code.

Editor's Note: In December 2003, Cmdr. de Lara deployed to Iraq. He will continue to provide articles.

DU Policy

—Continued from Page 6

ity and low-level radioactivity. Heavy metal toxicity is the major concern and can cause kidney damage. The radioactivity is a theoretical risk. However, the Centers for Disease Control's Agency for Toxic Substances and Disease Registry has stated no cancer or leukemia has been associated with exposure to natural or depleted uranium.

The departments of Defense and Veterans Affairs continue to partner on health care for depleted uranium exposed individuals. The VA established an ongoing depleted uranium exposure-monitoring program in 1993 for servicemembers believed to have had the most severe depleted uranium exposures during the Gulf War. To date, according to the researchers following those highly exposed servicemembers, those with embedded fragments still have high urine levels of depleted uranium. However, there have been no instances of lung or bone cancer, or leukemia. If the urine uranium level is normal now, regardless of the exposure experienced, there is no reason for concern; it is those with fragments, who are still being exposed, who need to be followed. All Operation Iraqi Freedom service-members confirmed with Level I and II exposures will be offered referral to the Baltimore VA Medical Center's Depleted Uranium Medical Follow-Up Program through their primary care physicians.

For those who have concerns about potential exposures to depleted uranium and its associated health risks, they can call the Deployment Health Support Directorate's Direct Hotline toll-free phone number at (800) 497 - 6261 Monday through Friday from 9 a.m. to 9 p.m., Eastern Time, to have their concerns addressed. Or, if they prefer, people may e-mail at *special.assistant@deploymenthealth.osd.mil*.

More information about depleted uranium is available on the DeploymentLINK at *http://www.deploymentlink.osd.mil/du_library/*. ■

Health Care Providers Better Prepared To Care For Returning Troops

by lisa a. gates

When American troops who have returned from Afghanistan and Iraq visit their military doctor for the first time, they may be quizzed about their deployment experience. Defense Department health officials say that servicemembers should not be alarmed by the questions. DoD has simply initiated a new policy and procedure to ensure that military health care providers thoroughly care for military personnel involved in deployments and their families.

"Answers to the questions will help the military health care provider determine if the servicemember has any deployment-related health problems that may need treatment," said Dr. Francis L. O'Donnell of the Deployment Health Support Directorate.

The questions are based on the new Post-Deployment Health Evaluation and Management Clinical Practice Guideline, often referred to as the post-deployment CPG, put into practice more than two years ago across the nation at both military and Department of Veterans Affairs health care facilities. The guideline is designed to provide a systematic basis of care for military and VA patients who have health concerns related to a deployment.

> "If a servicemember is injured or becomes ill following a deployment, we have a special responsibility to deliver the best medical care possible."

"This guideline serves as a way to implement a model of care that we've been promoting for Gulf War veterans and people with health concerns after other military deployments," said U.S. Army Lt. Col. (Dr.) Charles Engel.

The use of clinical practice guidelines within the medical community is nothing new. Clinical practice guidelines are developed by medical professionals to assist health care workers in determining patients' diagnoses and in selecting possible treatments. In many cases, the guidelines provide a brief description of the particular disease or illness, the results of recent research on the condition, and possible treatment protocols that are most likely to work for the patient.

The post-deployment clinical practice guideline was more than two years in the making. Developers of the guideline took advantage of lessons learned in evaluating and treating health concerns presented by 1991 Gulf War veterans, and incorporated basic advances in medicine, especially evidence-based medicine.

Military health officials are confident that the use of the newly established clinical practice guideline will be a great improvement over the way that 1991 Gulf War veterans were cared for. The guideline calls for primary care providers to ask every new patient if the reason for their visit is related to a deployment. If the servicemember believes that is the case, then the provider can follow the CPG in assessing the patient's symptoms or concerns. In short, the guideline focuses on the potential for health consequences of deployments and prescribes a thorough, methodical approach to medical evaluation.

"DoD health care providers are committed to taking care of military personnel and their families," said Dr. Michael Kilpatrick, deputy director, Deployment Health Support Directorate in the office of the deputy assistant secretary of defense (health affairs) for force health protection and readiness.

"In addition to keeping servicemembers healthy in order to accomplish the military mission," he said, "DoD providers have the other, unique challenge of dealing with the possible health effects of overseas deployments and combat. If a servicemember is injured or becomes ill following a deployment, we have a special responsibility to deliver the best medical care possible."

The practice guideline, Kilpatrick added, is a very useful and well-designed tool to aid providers in living up to that responsibility.

In the years immediately following the 1991 Gulf War, DoD had no special procedures in place to deal with the health problems of the veterans of that conflict. When it became evident that the usual system of DoD health care did not adequately provide for the special concerns of these veterans, DoD established in 1994 the Comprehensive Clinical Evaluation Program as a way of providing in-depth medical evaluations.

Although the emphasis placed on the CCEP enabled thousands of Gulf War veterans to undergo detailed medical examinations, the program had several limitations. Care within the CCEP tended to be "stove-piped," meaning that the care was not well integrated with family and non-deployment health care. The records of the CCEP evaluations were kept separate from the

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On Your Mark. Get Set. Go!

National Guard Bureau Distributive Training Technology Project Provides Support for Deployments

by maj stephan picard
ngb-j6, joint IT programs

The past decade has seen a dramatic increase in the number of National Guard and Reserve Component mobilizations and deployments. In fact, more National Guard members and Reserve troops have been mobilized since the 1991 Gulf War than in the preceding 36 years. Since Sept. 11, 2001, the United States has deployed more than 150,000 National Guardsmen and women, approximately 27 percent of its current total force.

With increased deployments come an increased need for resources to support the mobilized troops and their families. The National Guard Bureau Distributive Training Technology Project, or DTTP, a state-of-the-art communications and learning-delivery system, is playing a key role in meeting this need. By leveraging its advanced distributed learning and communications technologies, DTTP helps soldiers prepare for their missions, take care of personal matters prior to deployment, and, once deployed, communicate with their loved ones from thousands of miles away.

Distributive Training Technology Project

DTTP supports the National Guard's expanding operations at home and abroad. Its congressionally mandated missions are to improve military readiness; enhance command, control, communications, and computers (C4); and energize America's communities by providing shared access to high-performance communications, research, and development tools. There are more than 300 specially designed multimedia classrooms throughout the country, linked by a terrestrial network and emerging satellite technologies. These classrooms support such varied activities as military occupational training; language-sustainment training; first-responder instruction; terrorism-preparedness training; emergency operations support; communications support, and scientific-education programming aimed at school-age children.

Mission Readiness

One of Distributive Training Technology Project's top priorities is to ensure that National Guard troops are prepared for their missions. To do so, it offers its users a wealth of training courseware and content, covering such topics as anti-terrorism; nuclear, biological, and chemical warfare; emergency first response; combat skills; medical training; and military training.

Recently, Distributive Training Technology Project added 14 new Web-based military training packages to its Guard Collaborative Learning Source, a system for managing distance-learning and online training programs, and for promoting collaboration, knowledge management, and document sharing throughout the Distributive Training Technology Project community. These training packages, collectively known as Virtual Mission Preparation, were originally developed by Pennsylvania-based Mountain Top Technologies, Inc., to support the 28th Infantry "Keystone" Division's deployment to Bosnia.

The VMP training courses, which are certified by the Army's Training & Doctrine Command, were designed to support pre-deployment training for soldiers in advance of new missions. They also satisfy a number of the Army's "common core" training requirements — special proficiencies such as Hot/Cold Weather Injury Prevention, Mine Awareness, and Operational Security — that all soldiers must demonstrate.

Distributive Training Technology Project also offers more than 30 computer-based language courses, ranging from basic "survival" language instruction to higher-level proficiency training. This content, too, supports deployment activities. For example, in 2002 the Colorado National Guard used the DTTP classroom in Denver to enhance the language skills of approximately 150 soldiers being deployed to Afghanistan. The soldiers used lan-

guage software and video instruction to study Pashto, a main Afghan dialect spoken primarily along the Pakistan border. Distributive Training Technology Project even provided a modified version of the courseware on CD-rom so that the soldiers could continue their study and practice after deployment.

Preparation for Deployment

In addition to their rigorous training activities, soldiers preparing for deployment must also ensure that they put all their affairs in order prior to departure. Many soldiers use DTTP's resources to help ensure that they and their families are ready for the challenges associated with their deployment.

In Edinburgh, Ind., for example, soldiers at the Camp Atterbury Federal Mobilization site make double use of DTTP resources. During the day, the classroom is used almost exclusively to enhance soldier readiness for deployment. In the evenings from 5 to 10 p.m., distance learning officials open the classroom as a "Cyber Café" to all soldiers wishing to check their e-mail and military accounts, take care of personal matters, and communicate with family members. In March and April 2003, when Camp Atterbury was at its busiest, nearly 10,000 soldiers logged in more than 327,000 minutes of use at the Distributive Training Technology Project facility.

To provide additional support for deployment preparation, DTTP acquired another set of VMP training packages — these targeting family needs — to help the spouses and families of soldiers who have been or will be deployed. The 14 new family-support packages cover a range of useful information — from details on health care and other benefits to pay calculators for use in determining Overseas and Hazard Duty Pay.

The Next Best Thing to Being There

Once deployed, National Guardsmen and women can serve for as much as a year before they return to their loved ones back home. To maintain troop morale and give peace of mind to the deployed troops and their families alike, DTTP uses its high-tech resources to establish virtual visits. These sessions, which leverage DTTP's video-teleconferencing equipment and technologies, typically involve multiple families and enable each to meet privately with their deployed loved ones for approximately 10 minutes. Although brief, these face-to-face meetings have played an enormous role in boosting troop morale and alleviating the fears and uncertainties of those they leave behind.

The Missouri Army National Guard, which has deployed 2,200 men and women since March 2003, has been especially active in this regard. The Missouri Army National Guard conducts at least three video teleconferences weekly from its DTTP facility in Jefferson City, Mo. The Missouri Army National Guard also makes use of portable video teleconferencing equipment to achieve some surprising results. In June 2003, when Excelsior Springs Senior High School student David Yadon mounted the stage to receive his diploma, he was shocked to see his father beaming proudly from a large screen near the stage. Master Sgt. Michael Yadon, deployed to Bosnia, had promised his son that he would be back for his graduation. When that proved impossible, Yadon arranged the next best thing: a live video teleconference. On the morning of the graduation, Master Sgt. Yadon watched the whole commencement program while sitting 5,000 miles — and seven time zones — away.

The Missouri Army National Guard has also used its communications technologies to support such diverse activities as a July 4 cookout that included U.S. families and their loved ones in Bosnia, and, most recently, the Engineers Ball at Fort Leonard Wood, Mo., which was broadcast to a battalion of engineers stationed in Iraq.

As the number of deployments has risen, so too has the demand for tools that support training and communications. Using its advanced technologies, the Distributive Training Technology Project is helping to satisfy the needs of citizen-soldiers and their families, both at home and wherever duty takes them.

For more information about Distributive Training Technology Project support for deployed troops and their families, please contact DTTP Business Operations at *dttp@busops.ngbcio.ngb.army.mil*, or visit the Guard Collaborative Learning Source Web site at *https://www.gcls.ngb.army.mil/*. ■

An instructor from the military department teaches the Transportation-Automated Command and Control Information System software to soldiers mobilizing at Camp Atterbury, Ind.

Courtesy photo from the Indiana National Guard

Health Care

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permanent health records unless the servicemember requested them to be combined. The CCEP typically focused on diagnostic evaluation and subsequent care may not have been carefully linked to this diagnostic process.

> *"A single provider ensures that diagnosis and treatment for each deployed veteran is continuously coordinated, regardless of how many different tests or consultants are needed."*

As a result of these difficulties with health care coordination within the CCEP diagnostic process, servicemembers' usual primary care doctors were unaware of CCEP findings and unable to fashion complete and accurate care plans. Duplication of diagnostic tests sometimes occurred. These inefficiencies and fragmentation of care detracted from the otherwise well-intentioned effort by the CCEP to provide good care to Gulf War veterans.

In recent years, the Institute of Medicine of the National Academy of Sciences reemphasized the importance of sound medical care for previously deployed servicemembers, stressing that care should be coordinated in primary care and should start as soon as possible after the onset of health problems. The IOM also endorsed the development of the post-deployment CPG as important in guiding care, focusing the training of primary care providers, and as a tool for related research.

"The IOM's recommendations about practice guidelines were directed largely at unexplained symptoms arising after deployments," said O'Donnell. "The IOM was struck by how common such symptoms are in military personnel after wars and in the general population."

Now with the post-deployment Clinical Practice Guideline in place, primary health care providers are able to evaluate the total health picture of the patient, preserve continuity of care, manage specialty referrals, and monitor the effects of any needed treatments. An added benefit of the new guideline is its emphasis on complete and uniform diagnostic coding so that registries may be developed using administrative medical data. This keeps everyone up to date on what kinds of medical issues are identified in returning military personnel and families and helps to ensure that anyone with a given diagnosis gets appropriate, sensitive, and maximally private care.

"Basically the health care process has been unified," continued O'Donnell. "A single provider ensures that diagnosis and treatment for each deployed veteran is continuously coordinated, regardless of how many different tests or consultants are needed."

For those 1991 Gulf War veterans still on active duty, it is still possible to request an evaluation based on the old CCEP model.

"We get four or five calls a week from Gulf War veterans who want a medical evaluation," said Marie Martinucci of the Deployment Health Support Directorate's contact center. "We usually try to educate them briefly about the new post-deployment CPG and encourage them to have an evaluation based on that guideline. For those who want a health evaluation based on the CCEP procedures or who want to continue the CCEP process, we encourage them to call DoD's toll-free phone number at (800) 796-9699 or, if they are no longer eligible for DoD health care, the VA's toll-free number at (800) 749-8387 to schedule an exam."

According to Engel, who heads up the Deployment Health Clinical Center at Walter Reed Army Medical Center in Washington, D.C., those veterans currently enrolled in the CCEP and undergoing evaluation can complete that process.

Those whose symptoms no longer persist or who choose not to continue the process will always be welcomed later by their primary care provider if their symptoms reappear or if they are experience new problems related to the 1991 Gulf War or any other deployment.

For more information about the Post-Deployment Health Evaluation and Management Clinical Practice Guideline, visit the PD Health Web site at *http://www.pdhealth.mil*.

If you wish to speak to someone about your deployment-related concerns or problems, call the Deployment Health Support Directorate's contact center at (800) 497 – 6261, Monday through Friday, from 9 a.m. to 9 p.m. Eastern Standard Time. ■

'Golden Hour' Box Gets Blood To Front Quicker

by karen fleming-michael
u.s. army medical research and material command

new device inspired by an old idea may help save the lives of soldiers on battlefields.

The new Golden Hour blood container created by a contractor in Minnesota brought to fruition the vision of a three-person staff at the Blood Research Department at Walter Reed Army Institute of Research.

"Things converged about a year ago when the military was in Afghanistan," said Army Col. Tom Reid, chief of the blood research center at Walter Reed. "A number of surgeons who were there came back in April 2002 and said they were concerned about getting blood far forward ... because there are small groups going out and face delayed evacuation time."

During those discussions the recurring question the surgeons asked was 'Do we actually need blood far forward and, if so, what are we doing about it now?'" Reid said.

Though carrying blood far forward in the field is not doctrine, "obviously medics and soldiers in the field do what they have to do. If they think they need to get blood forward, they will get it forward," said Dr. Victor Macdonald of the institute.

Transporting blood, which is regulated by the Food and Drug Administration, is no simple task, said Army Col. John Holcomb, a trauma surgeon and the Army Surgeon General's trauma consultant.

"You can't just throw it in your ruck[sack] like you can with IV solutions," Holcomb said.

In the past, medics put units of red blood cells in coolers filled with wet ice to keep blood at its optimal temperature of between 1 and 10 degrees Celsius.

"When you're [outside] temperature is 110 degrees Fahrenheit or is cold, the units of red blood cells won't stay at the right temperature for very long," Macdonald said. When blood isn't kept at the right temperature, the cell membranes break down in a process called hemolysis."

"At some point, you start causing significant harm to the patient, like kidney failure and death," if you give bad blood to patients, Holcomb said.

After creating five or six prototypes, the Minnesota company arrived at the Golden Hour container. Its name is based on the tenet that beating the effects of shock within the first hour of injury — by giving a blood transfusion, for instance — is vital to trauma patients' survival.

"We bleed out the oxygen-carrying capability on to the ground, and at some point you get sick enough that you need to replace that," said Holcomb, who also is the commander of the U.S. Army Institute of Surgical Research in San Antonio, Texas.

The container, a nearly 10-inch-square box that needs no power source to maintain its internal temperature, uses a combination of the vacuum-insulated panels and an internal container that has a liquid phase-change material, like the reusable freezer packs people toss in coolers.

"The black, internal portion of the container is put in a refrigerator or freezer for at least two hours, then is put back in the container along with the units of red blood cells. The lid is put on, and that's it," Reid said.

The container, which has a strap for carrying and holds four units of red blood cells, weighs 10 pounds when it's full, Reid said.

"The point of the box is for the medic to have blood with him, ready to use when he needs it," Reid said.

How long the blood stays useable in the container depends on the outside temperature, said Army Lt. Col. Frank Rentas, assistant chief of blood research at WRAIR.

In tests run at the Blood Research Department, when the outside temperature is -9 degrees Fahrenheit (below freezing), the red blood cells stayed good for more than 97 hours; at 105 degrees Fahrenheit, they're good for more than 78 hours; and at room temperature, they can last 121 hours.

"The beauty of this is that the box isn't just good for red cells, but for anything that needs to be transported forward like biologicals, vaccines or reagents," Rentas said.

The research team at Walter Reed is already looking at a second-generation box that can constantly monitor the internal temperature of the box.

Web Site Helps Parents, Children With School, Deployment Issues

by gerry j. gilmore
american forces press service

A Web site, created to help service-members, spouses and children navigate the challenges associated with military moves and deployments, debuted last year.

Sponsored by the Defense Department, the site, *http://www.militarystudent.org*, offers advice and resource assistance for school transition issues, military deployments and more, John Molino, deputy under secretary of defense for military community and family policy, noted.

DoD has long recognized the need to disseminate helpful information to the field "for students who transition between schools as their [military] parents are reassigned," Molino explained. For years, he noted, the department "has tried to provide as good information as is available to facilitate that transition."

The emergence of the World Wide Web, he pointed out, "has been an excellent opportunity for us to take advantage of that technology, provide that information, and grow from there."

The site, Molino explained, contains school transition and deployment information targeted to the concerns of military parents, children age 6-12, teenagers, families with special-needs children, military leaders and educators.

Parents can access education-related information on transferring student records, graduation requirements and more.

The site also enables military children and teens to access tips and information to help them cope with family moves and military parent deployments, adapting to new schools, and making new friends.

Monitored children's and teens' "chat rooms" also are available on the Web site. The chat rooms, Molino pointed out, "will enhance the ability of children to share their own experiences, which will be most relevant in that age group."

Today's global war on terrorism, Molino pointed out, has brought the issue of deployments to the front burner for military families.

"In an age of increased deployments, it is more important to have this information on the Web site," Molino said. The war, he added, has made school districts more aware of the concerns of military families.

The site's overall purpose, Molino said, is to help servicemembers ' children succeed within the framework of the military lifestyle.

"These are not insurmountable problems," he said. "These are challenges, much like the challenges they will face for the rest of their lives.

"This [Web site] represents the department's commitment to facilitate success for our military children." ■

VA Launches 'Kids Page' Web Site

The Department of Veterans Affairs announced the launch of "VA Kids" in November 2003. The new Web page, *http://www.va.gov/kids*, designed to help young people understand what it means to be a veteran.

"The ideals of military service and patriotism can be unfamiliar to some children and young adults," said Secretary of Veterans Affairs Anthony J. Principi. "The VA Kids Web page supports President Bush's initiatives on education and volunteerism by providing an entertaining and informative way for young people to learn why veterans are special."

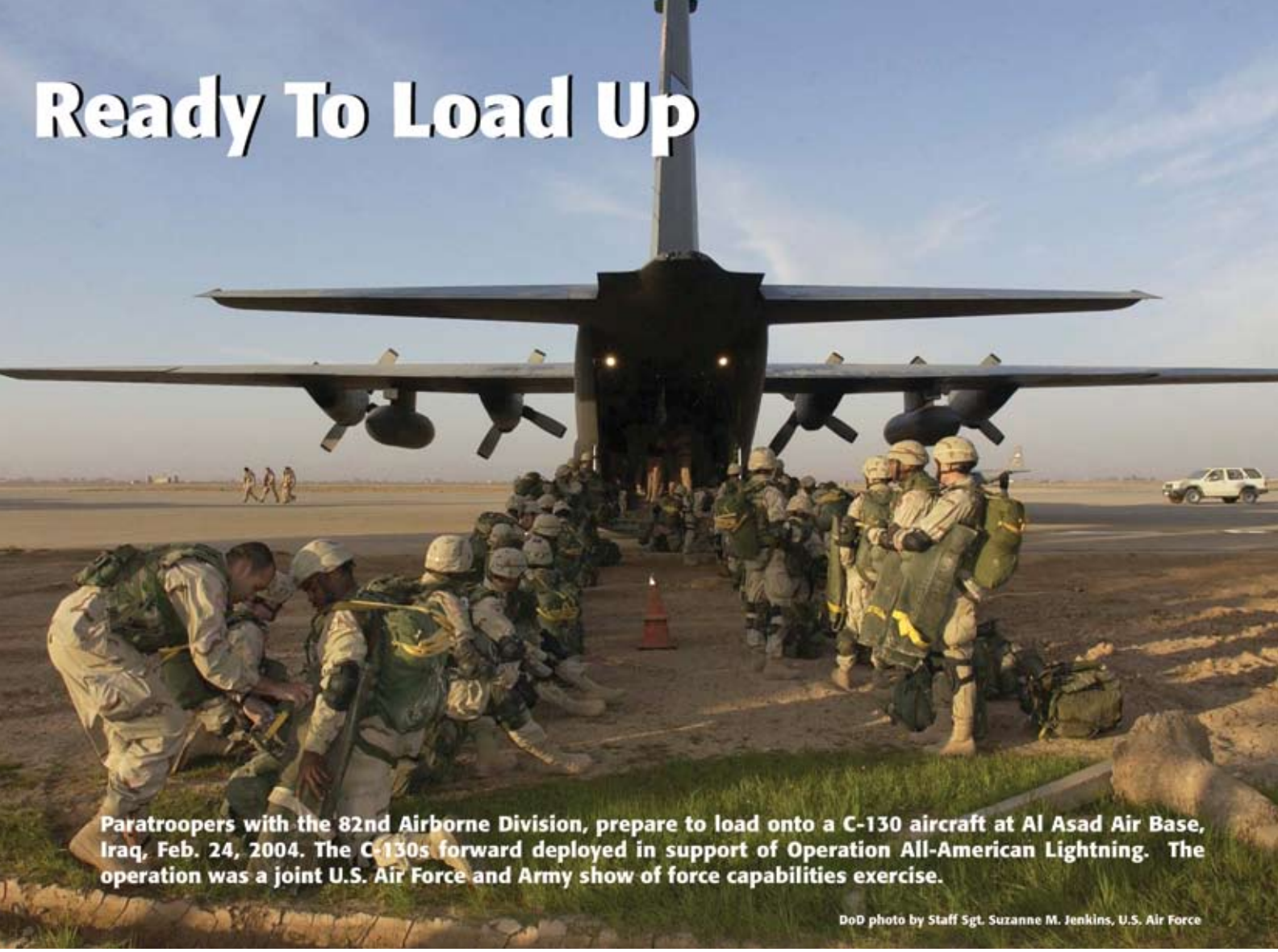
The site contains areas for students in kindergarten through Grade 5, for Grades 6 through 12, and for teachers. VA Kids also has information about VA, Veterans Day, scholarships, student volunteer opportunities, rehabilitative and special events for disabled veterans and links to veteran-related sites.

For younger students, the site has interactive activities such as puzzles, coloring pages, matching contests and age-appropriate language to describe a number of patriotic topics.

For older students, the page has information on volunteer programs, scholarships and more sophisticated educational resources, games and reference links. The teachers' section contains more information, links and suggested classroom activities.

"The title 'veteran' is bestowed by a grateful nation on citizens willing to sacrifice everything to preserve our freedom," Principi said. "It is our responsibility to honor these heroes by ensuring that each American generation understands what this prestigious title means." ■

Ready To Load Up



Paratroopers with the 82nd Airborne Division, prepare to load onto a C-130 aircraft at Al Asad Air Base, Iraq, Feb. 24, 2004. The C-130s forward deployed in support of Operation All-American Lightning. The operation was a joint U.S. Air Force and Army show of force capabilities exercise.

DoD photo by Staff Sgt. Suzanne M. Jenkins, U.S. Air Force

Courtesy photo

Army 1st Lt. Sarah Grivicic, 25, from Louisville, Ky., is an intensive care nurse assigned to the 28th Combat Support Hospital.

Army Nurse Thrives On Patient Care During OIF

by army public affairs

rmy 1st Lt. Sarah Grivicic wanted a challenge when she joined the Army three years ago. Now, she's an intensive-care nurse assigned to the 28th Combat Support Hospital, in support of Operation Iraqi Freedom.

Grivicic, 25, from Louisville, Ky., has the responsibility and challenge to ensure the most critically injured patients, both American and Iraqi, have the best medical care in the heart of Iraq.

"The hardest part is also the best part of my job — being with a dying soldier," Grivicic said.

Grivicic said she feels extremely privileged to be with a soldier during the soldier's last hours. "I never understood what 'an angel with a face' meant until my arrival in Baghdad," she said. "We are the last ones that they see or the last voice that they hear. It is our privilege to ensure that they are pain free in their last hours, that they are not alone and are never forgotten."

Just at the hospital barely over a month, Grivicic has already proven her abilities to the hospital's chief of nursing, Army Lt. Col. Theresa Sullivan, from New Jersey.

"She is motivated to do the job here," she said. "She truly cares for her patients. This little girl is what an Army nurse is all about." ■

Leaders Call For Re-Energized Suicide-Prevention Efforts

by g.w. pomeroy
air force surgeon general public affairs

fter experiencing 11 active-duty suicides since Jan. 1, 2004, and 14 during the final quarter of 2003, Air Force senior leaders are asking commanders and leaders across the service to assess and re-energize suicide prevention efforts at all levels.

The Air Force's 2003 calendar year suicide rate of 10.5 per 100,000 people was the lowest of all the military services and one-half the rate of a comparable civilian population of males between the ages of 20 and 50. As of Feb. 24, 2004, the service's suicide rate was 18.1.

In a letter sent to all major commands, the Air Force's acting assistant vice chief of staff urges all airmen to continue pitching in to reduce the number of suicides.

"Suicide is not stopped by medical personnel in emergency rooms; it is stopped by addressing quality-of-life issues in the unit on a daily basis," Air Force Lt. Gen. Richard E. Brown III wrote in the letter.

"The major components of the Air Force Suicide Prevention Program are active leadership involvement, an emphasis on community involvement and a focus on prevention throughout the life of airmen and their families, not just when they are suicidal," General Brown wrote.

"Pay special attention to the quality of your suicide-prevention briefings," wrote General Brown.

The Air Force requires active duty and civilian personnel to attend suicide-prevention briefings once during the 15-month air and space expeditionary force cycle.

In light of the recent suicides — none of which occurred during operations Enduring Freedom or Iraqi Freedom — General Brown urged commanders to "review how well we continue to implement the 11 initiatives that serve as the foundation of the Air Force Suicide Prevention Program."

The 11 initiatives are outlined in Air Force Pamphlet 44-160, Air Force Suicide Prevention Program: Description of Program Initiatives and Outcomes. The 11 initiatives are: build community awareness; leadership involvement; investigative interview policy; professional military education; epidemiological database; delivery of community preventive services; community education and training; critical incident stress management; integrated delivery system; limited patient-psychotherapist privilege and unit risk factor assessment.

Air Force leaders take a community approach in suicide prevention, encouraging every airman to take responsibility in reducing the number of suicides.

A key element of the program is to make a steady pipeline of suicide prevention tools available for Air Force people at all levels. So far in 2004, the Air Force Medical Service has issued the 2004 Leader's Guide for Managing Personnel in Distress, which is geared to help commanders, first sergeants and other leaders recognize when their people are distressed and how to respond appropriately. It also helps commanders link their people to resources and get them help as soon as possible.

The guide presents information on 35 distressing situations, provides checklists detailing potential behaviors or signs reflective of the person's reaction to the distressing event and responses or resources the leaders may want to use in responding to the person's needs. The guide was widely distributed as a CD-ROM to every squadron commander and first sergeant in the Air Force. The guide can be viewed on the dot-mil-restricted Air Force Suicide Prevention Program Web site, *https://www.afms.mil/afspp*.

Other suicide-prevention tools include:

- "The Air Force Guide for Managing Suicidal Behavior: Strategies, Resources and Tools," an 88-page clinical guide designed to assist mental-health professionals in assessing and managing high-risk behavior.
- The Air Force Suicide Prevention Web site, which is geared toward greatly improving access to suicide prevention information and materials.
- The 2003 Community Suicide Prevention Briefing, a new multimedia briefing that includes slides and video.
- The 2003 Leadership Suicide Prevention Briefing, a new multimedia briefing involving slides and video. This is geared toward wing, group and squadron commanders.

The service's suicide prevention program has received a great deal of acclaim and is commonly hailed as the best program of its type in the world. In December 2003, a landmark University of Rochester study of suicide in the U.S. Air Force concluded that the service's suicide prevention program reduced the risk of suicide by 33 percent during the past six years.

Also in 2003 the Air Force's Suicide Prevention Program was hailed as a "model program" in a landmark report released by the president's New Freedom Commission on Mental Health. In 2001, then-U.S. Surgeon General Dr. David Satcher made the program a model for the nation and incorporated it into the National Suicide Prevention Strategy.

In the mid-1990s — amid rising suicide rates in the military — Air Force leadership recognized that suicide is a community problem and the formal program was implemented in 1996. From 1991 to 1996, the active duty suicide rate was 14.1 per 100,000. During the seven years of the Air Force Suicide Prevention Program's existence, through the end of 2003, the suicide rate was 9.2 per 100K population. ■

Awareness Key To Suicide Prevention

by journalist seaman ryan c. mcginley,
commander, navy region hawaii
public affairs

Suicide is one of the top three causes of death in the Navy, according to the Department of the Navy Suicide Incident Report. It's a concern that hasn't subsided in recent years, and new approaches are being made to make sailors aware of the signs.

"More people die by suicide every year than by homicide, which is unbelievable to me," said U.S. Navy Lt. Cmdr. J P. Hedges, staff chaplain at Naval Station Pearl Harbor. "More service members have killed themselves than have died in battle."

> *"Suicide, it's a 49 to 51 vote, teetering back and forth, wanting the pain to stop but struggling, knowing [you] want to live."*

There are many indicators that all sailors should look out for in their workplace. The acronym AID LIFE helps co-workers to remember the process of intervening and approaching sailors who might be in trouble.

The first step is to ask if there is a problem. A shipmate might be noticeably depressed, or their work might be inconsistent with prior efforts. Asking the person if there is anything wrong is the first step to prevention.

"Open-ended questions are good, and you can quickly assess how bad off it is," said Hedges.

The next step is to intervene immediately. If the warning signs are evident, it's important not to dismiss or shy away from a problem.

"The handwriting is clearly there that there's something wrong with this picture, but because we don't like pain … we stray away from it and we minimize it," said Hedges.

"Above all else, someone who is contemplating suicide wants to know that someone else is concerned."

Once intervention is established, don't keep it a secret. Keeping the problem a secret denies the person help that they may need.

"It's about people," said Hedges. "We have to take care of people; that's really what suicide prevention is all about."

Then locate help immediately.

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Dorale, Djibouti — U.S. Navy Cmdr. Philip W. Perdue, a trauma surgeon with the Combined Joint Task Force - Horn of Africa Navy Emergency Medical/Surgical Team, checks the vital signs of a Djiboutian woman.

U.S. Marine Corps photo by Cpl. Paula M. Fitzgerald

Fleet Hospital Jacksonville Personnel Deploy To Djibouti

by loren barnes
naval hospital jacksonville
public affairs

More than 30 doctors, nurses and hospital corpsmen from Fleet Hospital Jacksonville deployed to the African nation of Djibouti Feb. 19.

They will join an expeditionary medical unit currently supporting the Combined Joint Task Force, Horn of Africa.

They will relieve 41 Fleet Hospital Jacksonville medical personnel who deployed with the expeditionary medical unit to Camp Lemonier, Djibouti, in September 2003, who are slated to return to Jacksonville in March.

"After being in the Navy 18 years, this will be a new experience for me," said Hospital Corpsman 1st Class Alan Scott.

Saying farewell to his wife and three children, Scott added, "I realized that the separation will be hard on them,

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Suicide Prevention

— Continued from Page 17

"Suicide, it's a 49 to 51 vote, teetering back and forth, wanting the pain to stop but struggling, knowing [you] want to live," said Hedges.

After that, inform the chain of command. The chain of command is there to help sailors and make sure they get the proper treatment that someone might need.

The final two steps are to find someone and expedite the process. Waiting too long can be a crucial mistake that could cost a life.

There are many reasons someone might consider taking their life.

"Relationship problems are the number one reason that we have problems," said Hedges. The relationship can be with a spouse, boyfriend, girlfriend, family or co-workers. The problem will lead to feelings of depression, anxiety or guilt, or to alcohol abuse. Other problems that can lead to suicide include financial, work, legal or disciplinary problems.

"With suicide, it's a desire to feel something other than pain."

Hedges hopes that everyone will take a proactive approach and care about their shipmates.

"They don't care how much you know, they want to know how much you care," said Hedges.

For more information, log onto *http://www.nhrc.navy.mil/programs/donsir/*. ■

Suicide Prevention Web Sites

Listed below are Web sites that offer information about suicide prevention:

The Centers for Disease Control and Prevention
http://www.cdc.gov/ncipc/factsheets/suifacts.htm

National Strategy for Suicide Prevention
http://mentalhealth.samhsa.gov/suicideprevention/

U.S. Navy Personnel Command's
Behavioral Health Branch
http://www.persnet.navy.mil/pers601/index.html

U.S. Navy Environmental Health Center's Suicide Prevention Web Site
http://www-nehc.med.navy.mil/hp/suicide/SLinks.htm.

U.S. Army Suicide Prevention
http://134.11.73.3/Suicide%20Prevention%20Resources.htm

U.S. Marine Corps Suicide Prevention
http://www.usmc-mccs.org/perssvc/prevent/suicide.asp

U.S. Coast Guard Suicide Prevention Program
http://www.uscg.mil/css/worklife/SUICIDE1.html

U.S. Navy photo

Horn of Africa — Hospital Corpsman Chris Barnes, assigned to the expeditionary medical unit, x-rays a patient's arm in the newly built radiology room. The Navy's first expeditionary medical unit has expanded their medical care to a Level III environment for personnel supporting Combined Joint Task Force - Horn of Africa.

Hospital Deploys

— Continued from Page 17

but the experience should prove challenging and rewarding."

"I really don't know exactly what to expect," said Hospital Corpsman 2nd Class Christine Hobbs. "From what I've heard, it should be pretty exciting."

> *"I realized that the separation will be hard on them, but the experience should prove challenging and rewarding."*

The CJTF-HOA, including medical personnel from Fleet Hospital Jacksonville, has been involved in humanitarian aid through the Medical Civil Action Program, reaching out with much needed medical care to the civilian population of Djibouti City.

Delivering a prayer as the medical personnel prepared to ship out, Hospital Chaplain Lt. Jason R. Hefner said, "You will be bringing a lot of caring to people who need it — and who better to deliver it?"

Fleet Hospital Jacksonville is the largest of the hospital's deployable platforms. As part of the hospital's dual mission, most of the military staff are assigned to platforms that stand ready to deploy anywhere in the world.

This unit is the Navy's first expeditionary medical unit. This deployment will expand medical care to personnel supporting coalition forces in the region by providing expanded sick call hours, casualty receiving, an intensive care/medical-surgical unit, operating room, laboratory and radiology unit. The EMU also provides specialty consultation services in orthopedics, general surgery, sports medicine, hand surgery and internal medicine. This significantly expands medical care to those who might not otherwise have access to these specialists, prevents needless medical evacuations out of theater, and directly translates to quicker recovery for injured or ill personnel. ■

RE- guide

Air Force Association
1501 Lee Highway
Arlington, VA 22209-1198
Phone: (800) 727 - 3337
http://www.afa.org

American Legion
1608 K St., NW
Washington, DC 20006
Phone: (202) 861 - 2700
http://www.legion.org

American Red Cross
17th & D Streets, NW
Washington, DC 20006
Phone: (202) 639 - 3520
http://www.redcross.org

AMVETS
4647 Forbes Blvd.
Lanham, MD 20706
Phone: (877) 726 - 8387
http://www.amvets.org

Association of the U.S. Army
2425 Wilson Blvd.
Arlington, VA 22201
Phone: (800) 336 - 4570
http://www.ausa.org

Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20400
Phone: (202) 273 - 4300
http://www.va.gov

Disabled American Veterans
807 Maine St., SW
Washington, DC 20024
Phone: (202) 554 - 3501
http://www.dav.org

Enlisted Association of
the National Guard
3133 Mount Vernon Ave.
Alexandria, VA 22305
Phone: (800) 234 - 3264
http://www.eangus.org

Fleet Reserve Association
125 N. West St.
Alexandria, VA 22314-2754
Phone: (703) 683 - 1400
http://www.fra.org

Marine Corps Association
715 Broadway St.
Quantico, VA 22134
Phone: (866) 622 - 1775
http://www.mca-marines.org

Marine Corps League
8626 Lee Highway, Suite 201
Merrifield, VA 22031
Phone: (800) 625 - 1775
http://www.mcleague.org

The Military Order of the
Purple Heart
5413-B Backlick Road
Springfield, VA 22151-3960
Phone: (703) 642-5360
http://www.purpleheart.org

Military Officers Association
201 N. Washington St.
Alexandria, VA 22314
Phone: (800) 234 - 6622
http://www.moaa.org

National Association for
Uniformed Services
5535 Hempstead Way
Springfield, VA 22151
Phone: (800) 842 - 3451
http://www.naus.org

National Committee for Employer Support of the Guard and Reserve
1555 Wilson Blvd., Suite 200
Arlington, VA 22209-2405
Phone: (800) 336 - 4590
http://www.esgr.org

National Guard Association
of the United States
1 Massachusetts Ave., NW
Washington, DC 20001
Phone: (202) 789 - 0031
http://www.ngaus.org

National Military Family Association
2500 North Van Dorn St., Suite 102
Alexandria, VA 22302
Phone: (800) 260 - 0218
http://www.nmfa.org

Naval Reserve Association
1619 King St.
Alexandria, VA 22314-2793
Phone: (703) 548 - 5800
http://www.navy-reserve.org

Navy League
2300 Wilson Blvd.
Arlington, VA 22201
Phone: (800) 356 - 5760
http://www.navyleague.org

Reserve Officers Association
1 Constitution Ave., NE
Washington, DC 20002
Phone: (800) 809 - 9448
http://www.roa.org

Paralyzed Veterans Association
801 Eighteenth St., NW
Washington, DC 20006-3517
Phone: (800) 424 - 8200
http://www.pva.org

Veterans of Foreign Wars
200 Maryland Ave., NE
Washington, DC 20002
Phone: (202) 543 - 2239
http://www.vfw.org

Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910-3710
Phone: (301) 585 - 4000
http://www.vva.org

OTHER RESOURCES

By Phone

Direct Hotline for Servicemembers, Veterans and Families
(800) 497 – 6261

Deployment Health
Clinical Care Center
(800) 559 – 1627

TRICARE Active Duty Programs
(active duty and family members)
(888) DOD – CARE
or (888) 363 – 2273

TRICARE Mail Order
Pharmacy - Express Scripts
(866) 363 – 8667

TRICARE Dental Program
(TDP) - United Concordia
(800) 866 – 8499

TRICARE Pharmacy Program
(877) DOD – MEDS
or (877) 363 – 6337

TRICARE For Life
(888) DOD – LIFE
or (888) 363 – 5433

TRICARE Retiree Dental
Plan – Delta Dental
(888) -838 – 8737

Defense Enrollment Eligibility Reporting
Systems (DEERS)
(800) 538 – 9552

TRICARE Online
(866) DOD – EWEB
or (866) 363 – 3932

Health Insurance Portability
Accounting Act (HIPAA)
(888) DOD – HIPA
or (888) 363 – 4472

Department of Veterans Affairs
(800) 827 – 1000

VA Gulf War Registry
(800) 749 – 8387

VA Benefits and Services
(877) 222 – VETS
or (877) 222 – 8387

Web Links

Department of Defense
http://www.defenselink.mil

DeploymentLINK
http://deploymentlink.osd.mil

GulfLINK
http://www.gulflink.osd.mil

MedSearch
http://www.gulflink.osd.mil/medsearch

DeployMed
http://deploymentlink.osd.mil/deploymed/

PDhealth
http://www.pdhealth.mil

Hooah 4 Health
http://www.hooah4health.com/

TRICARE
http://www.tricare.osd.mil/

Department of Veterans Affairs
http://www.va.gov/